STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445244	A. BUILDING 01 - MAIN BUILDING 01 B. WING	07/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CLEVELAND	3530 KEITH ST NW CLEVELAND, TN 37311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 017 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the fire rated walls. The findings include: Observation on July 22, 2013 at 2:35 p.m. revealed that the four (4) hour fire wall has a large unsealed penetration above the sprinkler piping. This finding was confirmed by maintenance and acknowledged by the administrator during the exit conference on July 22, 2013.	K 017	**What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice;** The unsealed penetrations revealed in the fire wall above the sprinkler piping were repaired by the Maintenance Director. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All other fire walls were inspected by the Maintenance Director to ensure there were no penetrations. **What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; and** The Maintenance Director will inspect areas that contractors have worked to ensure no penetrations were left unsealed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** The Administrator will monitor this corrective action to ensure continued compliance.	08/09/13
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 018	Continued From page 1 Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation, the facility failed to have corridor doors resist the passage of smoke. The findings include: Observation on July 22, 2013 at 11:30 a.m. and 11:50 a.m. revealed louvered doors in the following locations: 1. East Wing corridor time clock room. 2. East Wing time boiler room. 3. Skilled Wing corridor employee room. 4. Skilled Wing boiler room. These findings were verified by maintenance and	K 018	**What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice;** The East Wing corridor time clock room, East Wing time boiler room, skilled wing corridor employee room, & skilled wing boiler room doors will have the louvered area covered with a solid plate. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All other doors in the center have been checked by the Maintenance Director and were found to be in compliance. **What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; and** All doors in the center will be checked on a quarter basis by the Maintenance Director to ensure we meet NFPA 101 Life Safety Code Standards. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** The Administrator will monitor this corrective action to ensure continued compliance.	08/09/13

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K 018	Continued From page 2 acknowledged by the administrator during the exit conference on July 22, 2013.	K 018		
K 027 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and testing, the facility failed to have fire doors positively latch. The findings include:	K 027	**What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice;** Upon observation on the 3 hour fire door that would not latch, hardware has been ordered to replace existing hardware to be in compliance. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility corridor doors were inspected by the Maintenance Director to insure proper closure. **What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; and** The 3 hour fire door will be inspected at each fire drill by the Maintenance Director to ensure proper latching and adjustments. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** The Administrator will monitor this corrective action to ensure continued compliance.	08/06/13
	Observation on July 22, 2013 at 2:30 p.m. revealed that the 3 hour fire doors would not positively latch upon testing. This finding was confirmed by maintenance and acknowledged by the administrator during the exit conference on July 22, 2013.			
K 061 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1	K 061	**What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice;** Upon observation the facility did not identify that there is an indicating valve for an Automatic Sprinkler System.	08/08/13

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K 061	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide a listed indicating valve for the automatic sprinkler system in an accessible location, so located as to control all automatic sources of water supply. The findings include: Observation, record review and interview with maintenance, administration, and sprinkler technician on July 22, 2013 at 1:00 p.m. revealed that there is no indicating valve for the automatic sprinkler system for water shut off. This finding was confirmed by maintenance and acknowledged by the administrator during the exit conference on July 22, 2013.	K 061	**How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** We consulted the Cleveland Fire Department Fire Inspector in regards to the current Automatic sprinkler system set up. **What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; and** Upon review, the Cleveland Fire Department has generated a letter to the facility stating that all automatic sprinkler system standards are in compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** The Administrator will monitor this corrective action to ensure continued compliance.	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to install and maintain the automatic sprinkler system. The findings include:	K 062	**What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice;** Upon observation, the facility did not have documentation of the full flow trip test for the dry system. Further review identified no low point drains for the dry system. Outside contractor will install low point drain and perform a full flow trip test at completion.	08/06/13

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K 062	Continued From page 4 Observation, record review, and interview with administration and the sprinkler technician on July 22, 2013 at 11:30 a.m. and 1:00 p.m. revealed the following: 1. No full flow trip test for the dry system. 2. No auxiliary/low point drains for the dry system sprinkler. These findings were verified by maintenance and acknowledged by administrator during the exit conference on July 22, 2013.	K 062	**How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** The Maintenance Director will monitor and maintain supporting documentation to ensure all required testing is completed as required to be in compliance. **What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; and** The Maintenance Director will monitor and maintain supporting documentation to ensure all required testing is completed as required to be in compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** The Administrator will monitor this corrective action to ensure continued compliance.	